North Carolina
Department of Health and Human Services
Division of Medical Assistance

Medicaid Provider Enrollment Application for Group Physicians, Chiropractors, Optometrists, Podiatrists, Osteopaths and Dentists

Type or print all information in blue or black ink:

Applicant's Name: _____

Applicant's Telephone Number: (_____) _____
Area Code

Contact Person's Name: _____

Title: _____

Contact Person's Telephone Number: (_____) _____
Area Code

IMPORTANT INFORMATION

- **Return completed application and agreement to:**
  DMA Provider Services
  2501 Mail Service Center
  Raleigh, NC 27699-2501
- **Retain a copy of application and agreement for your file.**
- **Ensure you have the most current application and agreement. Visit our website at http://www.dhhs.state.nc.us/dma.**
- **Enroll as a Medicaid Managed Care / Carolina ACCESS Primary Care Provider at http://www.dhhs.state.nc.us/dma/caenroll.htm.**
- **Complete a separate application for an individual and group number.**
- **Contact DMA Provider Services at 919-855-4050 for any questions.**

Out-of–State Providers

Out-of-State physicians and dentists beyond the 40-mile border of North Carolina must complete a different application to enroll with the North Carolina Medicaid program in order to submit claims for reimbursement. To determine if the practice site is outside the 40 mile border, view the zip code table on our website at http://www.dhhs.state.nc.us/dma/Forms/provenroll/zip.pdf.

If you are located outside the North Carolina border and your zip code is not listed in this table please do not complete this application. Visit our website at http://www.dhhs.state.nc.us/dma/provenroll.htm and choose the Dentist Out-of-State or Physician Out-of-State Provider Application and Participation Agreement. Enrollment for out-of-state providers is not open-ended; enrollment is on a claim-by-claim basis for emergency medical services rendered to N.C. Medicaid recipients. Services provided **out-of-state** must be prior approved unless they are for a medical emergency in which the recipient's health would be endangered by returning to North Carolina before receiving treatment. For prior approval of outpatient services, call EDS at 1-800-688-6696 or 919-851-8888. For prior approval of inpatient psychiatric admissions, call ValueOptions at 1-888-510-1150.

In-State Providers

1. **A separate application is required for each Medicaid group.**

2. **Group Name:** _____

   Effective Date Requested: _____

3. **Enter the Federal Employer Identification Number (FEIN) if applicable. The information below must be completed if a provider is operating under DBA or legal business name. (Legal Business Name if applicable.)**

   FEIN#:_____
   ***FEIN Business Name should be consistent with how taxes are filed.**

4. **Enter the street address of the location where services will be rendered. Post office box addresses are not acceptable as physical addresses. If mail cannot be received at the physical address, enter the physical address first and the post office box second.**

_____
Business Site/Physical Address

_____
Box/Suite (if applicable)

_____
City **State** **Zip Code + 4 Digits (required)**

_____ _____
County of Business Site/Physical Address **Business Email Address**

(_____)_____ (_____)_____
Telephone Number **Fax Number**

5. **Enter the address where Medicaid payment information (remittance advice) should be sent. If this item is blank, the remittance advice will be sent to the address in Item 4.**

_____
Street Address for payment

_____
City **State** **Zip Code + 4 Digits (required)**

6. **Federal Employee Identification Number (group provider only)** _____

   Name Associated to FEIN (if any):_____

   An IRS Form W-9 must be submitted with an original signature with this application. See Attachment III for a sample.

7. **Check the appropriate provider type.**
   - ☐ **Physician Group**
   - ☐ **Dental Group**

8. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

   Taxonomy: ☐☐☐☐☐☐☐☐☐X
   ☐☐☐☐☐☐☐☐☐X
   ☐☐☐☐☐☐☐☐☐X

9. Medicare number: _____

10. Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable.

Certification Type: □ Regular □ Waiver □ Accreditation
□ Partial Accreditation □ Registration □ PPMP

CLIA Number: _____

Begin Date: _____/_____/_____ End Date: _____/_____/_____

10. Check the appropriate ownership type: ☐ Corporation (LLC, PLLC)
☐ Non-Profit Agency
☐ Partnership
☐ Sole Proprietorship
☐ Other

If other, please explain below:

_____

_____

_____

If the organization/agency is incorporated, please attach a copy of the Articles of Incorporation. This applies to all corporation types (LLC, PLLC,PA).

11. List all individuals or entities who have five percent or more ownership AND all individual officers, directors, managers, and Electronic Funds Transfer (EFT) authorized individuals and the information requested on each.

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies:			
	☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies:			
	☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies:			
	☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies:			
	☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None				

If more pages are necessary, please make copies of this page.

12. Have you or any of the individuals listed in Item 11 ever:
Please answer all sections (a –e) of this question.

a. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony?

Yes ☐ **No** ☐

If yes, list the name(s) of the individual(s) and provide a copy of the criminal complaint and final disposition:

_____

_____

b. Had any disciplinary action ever been taken against any business or professional license held in this or any other state? Or has your license to practice ever been restricted, reduced or revoked in this or any other state?

Yes ☐ **No** ☐

If yes:

Against Whom? _____
Action Taken? _____
Who Took Action? _____
Date of Action? _____

If yes, please attach a copy of the final disposition. Also attach documentation from the proper authorities approving the reinstatement of the license.

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?

Yes ☐ **No** ☐

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Provider Number

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state?

Yes ☐ **No** ☐

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Provider Number

e. Owed money to Medicaid or Medicare that has not been paid? Yes☐ No☐

13. Do you or any individuals, directors, or owners listed in Item 11 have ownership in any other Medicaid enrolled businesses?
Yes ☐ No ☐

If yes, list other Medicaid enrolled businesses you own and the names of all owners, with five percent or more ownership of the business. Attach additional pages if necessary.

Name of Owner	Name of Other Business	Provider Number

14. Is this application based on a change of ownership? ☐ Yes ☐ No
If yes, give date of ownership change: _____

If yes, give the previous ownership information:

Name Previous Owner	Address of Previous Owner	Medicaid Provider Number	Federal Tax ID

A change of ownership (CHOW) occurs whenever the stock or assets/liabilities of a business are purchased or transferred by the existing owners to new owners. New ownership of a Medicaid provider requires a new provider number. Medicaid provider numbers are not transferable. The following is a list of situations that generally are not considered a change of ownership:

- **Parent corporations absorb or merge with their fully owned sub-corporations;**
- **the owners and structure of the Medicaid enrolled entity remain the same; and**
- **the name of a company changes, but neither the company owners nor the federal tax identification numbers change.**

***Note:** A copy of the stock transfer document or bill of sale is required to document a change of ownership.*

CERTIFICATION STATEMENT

Complete the signature portion below. The application must contain an original signature and date. Copies and signature stamps are not acceptable. This section also requires the signature and date thereof of an "Authorized official" or delegate official who can legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicaid program. The "Authorized Officials" may delegate granting signature authority to a (Delegated Official) employed by the supplier for the purpose of reporting future changes to the supplier's enrollment record.

By his/her signature(s), the authorized or delegated official named below agree to adhere to the following requirements stated in this Certification Statement:

1) I agree to notify the Medicaid contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in the business structure of this supplier may require the submission of a new application.

2) I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicaid, or any deliberate alteration of any text on this application form, billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.

3) I agree to abide by the laws, regulations, and program instructions that apply to this supplier.

4) Neither the supplier, nor any 5% or greater owner, partner, officer, director, W-2 managing employee, authorized official or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicaid or other Federal program beneficiaries.

5) I agree that any existing or future overpayment made to the supplier by the Medicaid program may be recouped by Medicaid through the withholding of future payments.

6) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

_____ _____

Signature of Provider or Authorized Agent **Date**

_____

Typed or Printed Name & Title of Provider

Group Provider Application

If you are applying as an individual provider not affiliated with any group, disregard this Group Provider Application section.

Group providers who will be submitting Medicaid claims on behalf of their affiliated practitioners must complete this form. If filing claims *electronically* for practitioners affiliated with this group, *each* practitioner must sign the completed Electronic Claims Submission Agreement (see Attachment II). Group providers, who will be submitting *paper* claims, must have *each* practitioner affiliated with the group complete and sign the Provider Certification for Signature on File form (see Attachment I).

Group Name **Group Federal Employer Identification Number**

Number in Group **Specialty Type**

If applying for a group provider number, indicate the date the group was established____/_____/_____
MMDDYYYY

Individual provider's name and title (MD, DO, DPM, et al.). Please print.	NC License Number (nine digits)	Individual Medicaid Number (seven digits)

Individual provider's name and title (MD, DO, DPM, et al.). Please print.	NC License Number (nine digits)	Individual Medicaid Number (seven digits)

Individual provider's name and title (MD, DO, DPM, et al.). Please print.	NC License Number (nine digits)	Individual Medicaid Number (seven digits)

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Individual provider's name and title (MD, DO, DPM, et al.). Please print.	NC License Number (nine digits)	Individual Medicaid Number (seven digits)

Individual provider's name and title (MD, DO, DPM, et al.). Please print.	NC License Number (nine digits)	Individual Medicaid Number (seven digits)

Individual provider's name and title (MD, DO, DPM, et al.). Please print.	NC License Number (nine digits)	Individual Medicaid Number (seven digits)

If more pages are necessary, please make copies of this page.

CONSENT TO RELEASE OF INFORMATION

I understand that the North Carolina Division of Medical Assistance (DMA) is responsible for the evaluation of my professional training, experience, professional conduct, and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Medicaid Program. I understand and agree that as an applicant for participation in the Medicaid Program, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize DMA and its representatives to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between DMA and its representatives and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by DMA to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Program and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions acting in good faith and without malice for acts performed in gathering or exchanging information in this credentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Program's credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or DMA to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

A photocopy of this consent shall be as effective as an original when presented.

Provider's Signature or Authorized Agent: _____

Provider's or Authorized Agent Printed Name: _____
Date: _____

(Attach additional sheets if necessary)

DMA USE ONLY [ ] Initial Enrollment [ ] CHOW [ ] Renewal [ ] Other Effective Date: _____ Provider #_____

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
MEDICAID PARTICIPATION AGREEMENT

DMA Provider Services·2501 Mail Service Center Raleigh, NC 27699-2501·Telephone: 919-855-4050

Group Provider Name **Telephone Number**

Provider Site Street Address:

City **State** **Zip**

Provider Mailing Street Address:

City **State** **Zip**

1. Parties to the Agreement

This Agreement is entered into by and between the North Carolina Department of Health and Human Services, Division of Medical Assistance, hereinafter referred to as the "Division", and _____, hereinafter referred to as the "Provider."

2. Agreement Document

This Agreement shall consist of this Agreement and the Provider's application, incorporated herein by reference.

3. Governing Law and Venue

This Agreement shall be governed by the laws of the State of North Carolina. In the event of a lawsuit involving this Agreement, venue shall be proper only in Wake County, North Carolina.

The Provider is subject to and shall comply with all federal and state laws, regulations and rules, State Medicaid Plan, and policies, provider manuals, and Medicaid bulletins published by the Division and/or its fiscal agent in effect at the time the service is rendered, which are incorporated into this Agreement by this reference.

4. License

The Provider shall be licensed, certified, registered, or endorsed as required by State and/or Federal law at all times that services are provided. The Provider will notify the Division within seven (7) days of learning of any adverse action initiated against the license, certification, registration or endorsement of the Provider or any of its officers, agents, or employees. The Provider shall not bill the Division for services rendered during the lapse, for whatever reason, of any required license, certification, registration or endorsement as required by State and/or Federal law.

5. Billing and Payment

The Provider agrees:

a. To submit claims for services rendered to eligible recipients, as identified by the Division, in accordance with rules and billing instructions in effect at the time the service is rendered.
b. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered under the Program, except for payments from legally liable third parties and authorized cost sharing by recipients for goods, services, or supplies provided to a recipient if such are not covered by the Medicaid program. In no event shall the Division be responsible, either directly or indirectly, to any subcontractor or any other party that may provide services.
c. To be held to all the terms of this Agreement even though a third party may be involved in billing claims to the Division. It is a breach of this Agreement to discount client accounts (factor) to a third party biller or to pay a third party biller a percentage of the amount collected.
d. To bill other insurers and third parties, including the Medicare program, before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person.
e. To not charge the recipient or any other person for items and services covered by the Medicaid Program and to refund payments made by or on behalf of the recipient for any period of time the recipient is Medicaid approved, including dates for which the recipient is retroactively entitled to Medicaid.
f. To accept assignment of Medicare payment in order to receive payment from Medicaid for amounts not covered by Medicare for dually eligible recipients.
g. To refund and allow DMA to recoup any monies received in error or in excess of the amount to which the Provider is entitled from the Medicaid program as soon as the provider becomes aware of said overpayment or within 30 days of request for repayment by the Division, regardless of who caused the overpayment. Causes of overpayment include but are not limited to, lack of documentation for claimed services, improper billing, payments by third parties, failure to supply requested records, failure to disclose ownership interests, failure to disclose persons convicted of crimes associated with medical assistance programs, or failure to disclose sanctioned individuals.
h. That payment for covered services under Medicaid is limited to those services certified as medically necessary in the judgment of a qualified physician or other practitioner of the

healing arts, for the proper management, control, or treatment of recipient's medical problem and provided under the physician's or practitioner's direction and supervision.

i. That items or services provided under arrangements or contracts with outside entities and professionals meet professional standards and principles and are provided promptly.

j. That payment and satisfaction of this claim will be from federal, state and county funds, and that any false claims, false statements or documents, or misrepresentation or concealment of a material fact may be prosecuted by under applicable State and/or Federal law.

k. That the Division may withhold payment because of irregularity for whatever cause until such irregularity or difference can be resolved or may recover overpayments, penalties or invalid payments due to error of the Provider and/or the Division and its agents. If the Division withholds payment or is entitled to recovery, such withholding or assessment of recovery may be imposed on any and all provider numbers in which the healthcare provider has an interest or in which he may have an interest.

l. That billings and reports related to services to Medicaid recipients and the cost of that care shall be submitted in the format and frequency specified by the Division and/or its fiscal agent. Failure to file mandatory reports or required disclosures within the time-frames established by Division rule or policy may result in suspension of reimbursements and/or other enforcement actions.

m. That no Medicaid payment will be made for claims received by the Division later than twelve months following the date the service was provided, except that any periods of time exceeding thirty days, from the time the Provider requests an authorization to the time the authorization is sent to the Provider, shall be added to the twelve months.

n. To comply with all Health Insurance Portability and Accountability Act requirements.

6. Disclosure

The Provider agrees to submit to the Division professional, business, and personal information concerning the Provider, and any person with an ownership interest in, and any agent of, the Provider, including information as to any violation of regulations of any private insurer or payor. Such information shall include:

(I) Proof of holding a valid license or operating certificate, as applicable, if required by federal or state law or by rule or by a local jurisdiction in which the Provider is located.

(II) Any prior violation, fine, suspension, termination, or other administrative action taken under federal or state law or rule or the laws or rules of any other state relative to medical assistance programs, Medicare, or a regulatory body.

(III) Any prior violation of the rules or regulations of any other public or private insurer.

(IV) Full and accurate disclosure of any financial or ownership interest that the Provider, or a person with an ownership interest in the Provider, may hold in any other health care provider or health care related entity or any other entity with whom the Provider conducts business or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(V) If a group Provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the medical assistance programs.

The Provider agrees to submit to a criminal background check before or anytime after approval of this agreement. If the provider is found to be convicted of an offense outlined in paragraph 9, the Division may terminate the provider or deny approval of the application as described in paragraph 9.

At any time during the course of this Agreement, the Provider agrees to notify the Division of any material and/or substantial changes in information contained in the enrollment application given to the Division by the Provider. This notification must be made in writing within thirty (30) days of the event triggering the reporting obligation. Material and/or substantial changes include, but are not limited to changes in:

a.ownership;

b.licensure;

c.federal tax identification number;

d.additions, deletions, or replacements in group membership; and

e.any change in address or telephone number.

7. Inspection; Maintenance of Records; Filing Reports

For five years from the date of services, or longer if required specifically by law or post payment audits, the Provider shall:

a.Keep, maintain and make available complete and accurate medical and fiscal records in accordance with generally accepted accounting principles and Medicaid record-keeping requirements that fully justify and disclose the extent of the services or items furnished and claims submitted to the Division. For providers who are required to submit annual cost reports, fiscal records may include invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, and such other records as may be required by Division law or policy.

b.Furnish upon request appropriate documentation, including recipient records, supporting material, and any information regarding payments claimed by the Provider, whether in the possession of contractors, agents, or subcontractors, for review by the Division, its agents, the Centers for Medicare and Medicaid, the State Medicaid Fraud Control Unit of the Attorney General's Office and/or other entities as required by law. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the Division may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of the Provider from participation in the Medicaid program.

c.Post payment audits or investigation may be conducted to determine compliance with the rules and regulations of the Program. If the provider is notified that an audit or investigation is has been initiated, the Provider shall retain all original records and

supportive materials until the audit or investigation is completed and all issues are resolved even if the period of retention extends beyond the required 5-year period.

d. Federal and State officials and their agents may make certification and compliance surveys, inspections, medical and professional reviews, and audits of costs and data relating to services to Medicaid recipients. Such visits must be allowed at any time during hours of operation, including unannounced visits. Failure to allow such visits or grant immediate access upon reasonable request may result in suspension of reimbursements. .

8. Division Responsibilities

The Division shall:

a. Make timely payment at the established rate for services or goods furnished to a recipient by the provider in accordance with the policy in effect at the time the services are rendered.

b. Not seek repayment from the provider in any instance in which the Medicaid overpayment is attributable solely to error in the State's determination of eligibility of a recipient.

c. Enroll a provider in the Medicaid program if the provider has
1) Submitted an application, licensure, and other supporting documentation;
2) Agreed to the terms of this Agreement; and
3) Otherwise complies with the requirements for enrollment. Once approved, the Division will issue a unique Medicaid provider number to the provider.

d. Furnish to Provider, upon enrollment and on request thereafter, a current copy of the appropriate provider manuals. Current provider manuals, policy and bulletins will be available on the North Carolina Division of Medical Assistance website. Copies will also be available on request.

9. Termination

Either the Division or the Provider may terminate this agreement with or without cause at any time upon 30 days written notification to the other. The Division may summarily terminate without giving 30 days written notice under the following circumstances:

a. The Provider fails to meet conditions for participation, including licensure, certification, endorsement or other terms and conditions stated in this Agreement, or
b. The Provider is determined to have violated Medicaid rules or regulations, or
c. The Provider has been convicted of a criminal offense related to the delivery of an item or service under Title XVIII or under any State health care program, or
d. The Provider has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care items or service, or

e. The Provider has been convicted of an offense under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
f. Any person with ownership or control interest in the Provider or an agent or managing employee of the Provider has been convicted of a criminal offense related to services provided under titles XVIII, XIX, or XX of the Social Security Act, or
g. The Provider fails to provide medically appropriate health care services, or
h. The Division determines it to be in the best interests of the Medicaid Program and/or the Medicaid recipients to do so.

10. Assignment

The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement to a third party except as allowed by federal law.

11. Confidentiality

The Provider shall not use or disclose information concerning Medicaid recipients, except as provided in paragraph 7 above, including name and address, social and economic conditions or circumstances, medical data and medical services provided, except for purposes of rendering necessary medical care, arranging for medical care or services not available from the Provider, establishing eligibility of the recipient, and billing for services of the Provider. Neither recipient records nor portions thereof may be transferred except by written consent of the recipient or as otherwise provided by law.

12. Indemnification and Hold Harmless

The Provider agrees to indemnify and hold harmless the Division, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of the Provider or any subcontractor.

13. Severability

The provisions of this Agreement are severable. If any provision of the Agreement is held invalid by any court that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

14. Independent Contractor

The Provider or its directors, officers, partners, employees and agents are not employees or agents of the Division.

15. Availability of Funds

The parties to this Agreement understand and agree that the payment of the sums specified in this Agreement is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to the Division.

16. Discrimination

The parties agree that the Division may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with the Division; who is performing services or supplying goods in accordance with federal, state and local law; and who agrees to provide services to Medicaid eligible recipients of the same quality as are provided to private paying individuals and without regard to race, color, age, sex, religion, disability, or national origin.

17. Agreement Retention

The parties agree that the Division may only retain the signature page of this agreement, and that a copy of the standard provider agreement will be maintained by the Director of the Division, or his designee, and may be reproduced as a duplicate original for any legal purpose and may also be entered into evidence as a business record.

18. Electronic Claims Submission

I have read the conditions for submission of electronic claims contained in the enclosed Electronic Claims Agreement and hereby elect to:

☐ Submit claims electronically and to abide by the conditions for electronic submission.

☐ Not submit claims electronically at this time.

I understand that a separate agreement for electronic claims must be signed and approved if I elect to file claims electronically.

SIGNATURE OF PROVIDER:

By:

_____

Signature of Provider or Authorized Agent **Date**

_____

Typed Name and Title of Provider or Authorized Agent

_____

Name of Corporation **IRS Number**

DMA USE ONLY

EFFECTIVE DATE

This agreement is effective _____, subject to renewal on a periodic basis, or execution of a new agreement when DMA determines that changes in law, Medicaid regulation or policies or other material circumstances so require or by act of the parties as herein provided, or by operation of law.

DMA APPROVAL

Accepted on _____ by _____

Attachment I

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION

FOR

SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

_____

Print or Type Business Name of Provider

_____

Signature of Provider Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____

Mail or fax the completed form to:

EDS
Provider Enrollment
P.O. Box 300009
Raleigh, NC 27622
Fax: 919-851-4014

Attachment II

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

DMA Provider Enrollment, 2501 Mail Service Center Raleigh, NC 27699-2501

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

l. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.

2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.

3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.

4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.

5. The Provider shall notify DMA in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to DMA prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to DMA. For purposes of

compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature and all electronic media and electronic submissions), and shall ensure the claim can be associated with and identified by said source documents. Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors and as provided in paragraph 6 above, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.

8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.

9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.

l0. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.

11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This

agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.

12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.

13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.

14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.

16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

The undersigned having read this Agreement for billing Medicaid claims electronically and understanding it in its entirety, hereby agree(s) to all of the stipulations, conditions, and terms stated herein.

Group Provider Name

Business Site/Physical Address

City **State** **Zip Code**

Signature of Provider or Authorized Agent **Date**

Typed or Printed Name and Title of Provider or Authorized Agent

(Attachment II continued)

Provider Group Name:_____

List of individual provider names, numbers and signature, if billing as a group: (Complete for practices who will submit claims using a group provider number even if there is only one provider in the group, e.g., physicians, clinics, dentists, practitioners, etc.)

All provider signatures must be original. Signature stamps and copies are not acceptable.

Provider Name	Provider Individual Number	Signature of Provider

DMA/FISCAL AGENT APPROVAL:
Acceptance Date: _____ by _____

(Attach additional sheets if necessary)

Additional Taxonomy: